

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1602

## CERTIFICATE OF DEATH

01583

Reg. Dist. No. 62

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>NORMAN</u> Middle <u>WESLEY</u> Last <u>BAYNARD</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 26, 1895</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DAY LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Wesley Baynard</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Collins</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)			
16. SOCIAL SECURITY NO. <u>1</u>				17. INFORMANT <u>Mrs. Norman Baynard</u> Address <u>Denton</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Aug 4, 1957</u> to <u>Feb 29, 1956</u> , that I last saw the deceased alive on <u>Feb 12, 1956</u> , and that death occurred at <u>5:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Paul Knuth</u> M.D.				ADDRESS (Street, city or town, state) <u>Denton Md.</u>			
DATE SIGNED _____				DATE SIGNED _____			
PHYSICIAN'S NAME (Type) _____				PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 3, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's</u>		22d. LOCATION (City, town, or county) <u>near Denton Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. G. Mowbray</u> ADDRESS <u>Denton</u>				24a. REC'D BY REGISTRAR <u>2-1-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. O. George</u>	

# CERTIFICATE OF DEATH

BUREAU V. S.

MAR 8 1956

RECEIVED

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01584

## 1693 CERTIFICATE OF DEATH

Items 8,9, Film G194 4-2-56 et

Reg. Dist. No. 64

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Delaware</u>		COUNTY <u>Sussex</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Federalsburg</u>		LENGTH OF STAY (in this place) <u>1 month</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dagsboro</u>		<u>46x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>Dagsboro</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>I. Lemuel Brumbley</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2/13/56</u> 19			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 10, 1871 ?</u>	9. AGE last birthday <u>85 ?</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>3</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if		10b. KIND OF BUSINESS OR INDUSTRY <u>Foreman</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Brumblly</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Evans</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Raymond Brumbley - Dagsboro, Del</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cachexia &amp; Renal Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4-25-53</u>	
ANTECEDENT CAUSE(S) DUE TO (B)						<u>2-13-56</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-25-53</u> , 19 <u>53</u> , to <u>2-13-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-12-56</u> , 19 <u>56</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>Millshoro, Delaware</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>2/13/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/16/56</u>		NAME OF CEMETERY OR CREMATORY <u>Redmens Cemetary</u>		LOCATION (City, town, or county) (State) <u>Dagsboro, Del.</u>	
24. REC'D BY REGISTRAR DATE <u>Feb. 16, 1956</u>		REGISTRAR'S SIGNATURE <u>Margaret H. Frampton</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Federalsburg Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

11584

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

# 1903 CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Residence		Occupation		Cause of Death	
123 Main St.		Farmer		Heart Disease	
Date of Death		Place of Death		Time of Death	
Jan 10, 1903		Home		10:00 AM	
Physician		Burial		Interment	
Dr. Smith		St. Mary's		Cemetery	
Signature		Witness		Registrar	
[Signature]		[Signature]		[Signature]	

BUREAU V. S.

FEB 21 1906

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1694

01585

Reg. Dist. No. *60*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <i>Caroline</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Caroline</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Rural Henderson</i>		LENGTH OF STAY (in this place) <i>15 yrs.</i>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Rural Henderson</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>None</i>				STREET ADDRESS (If rural, give location) <i>None</i>			
<b>3. NAME OF DECEASED:</b> (First) <i>James</i> (Middle) <i>Edward</i> (Last) <i>Cohee</i> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) <i>2</i> (Day) <i>15</i> (Year) <i>56</i> <i>19</i>			
<b>5. SEX:</b> <i>Male</i>	<b>6. COLOR OR RACE:</b> <i>White</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED:</b> <i>Single</i>	<b>8. DATE OF BIRTH:</b> <i>8/7/1872</i>	<b>9. AGE last birthday:</b> <i>83</i> yrs.	<b>IF UNDER 1 YEAR</b> Months <i></i> Days <i></i>	<b>IF UNDER 24 HRS.</b> Hours <i></i> Min. <i></i>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of work life, <i>even if retired</i> ) <i>Retired Milk Mill</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY:</b> <i>None</i>		<b>11. BIRTHPLACE</b> (State or foreign country): <i>Maryland</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>	
<b>13. FATHER'S NAME:</b> <i>Nicholas Cohee</i>				<b>14. MOTHER'S MAIDEN NAME:</b> <i>Hattie ?</i>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) <i>No</i>		<b>16. SOCIAL SECURITY No.:</b> <i>184-10-6478</i>		<b>17. INFORMANT &amp; ADDRESS:</b> <i>Ora George Henderson, Maryland</i>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>							
<i>451X</i> <b>Immediate cause</b> (a) <i>Myocarditis Acute</i> <b>DUE TO</b>						<i>Sudden</i>	
<b>Antecedent cause(s)</b> (b) Diseases or conditions, if any, giving rise to the above cause stating <u>underlying cause last</u> (c) <b>DUE TO</b>							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH</b> <i>History of Heart disease</i>							
<b>19a. DATE OF OPERATION:</b>		<b>19b. MAJOR FINDING OF OPERATION:</b>				<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY</b>		<b>21c. (City or town) (County) (State)</b>			
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b> M. <i></i>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>SIGNATURE</b> <i>Danison D. George</i>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <i>2/16/56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>2/18/56</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Holly Wood</i>		<b>LOCATION (City, town, or county) (State)</b> <i>Harrington, Del.</i>	
<b>DATE REC'D BY LOCAL REG.</b> <i>2/17/56</i>		<b>REGISTRAR'S SIGNATURE</b> <i>Edith Smith</i>		<b>24. FUNERAL DIRECTOR</b> <i>J. E. Boulais &amp; Greensboro, Md.</i>		<b>ADDRESS</b>	

BUREAU V. R.

FEB 20 1956

RECEIVED



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01586

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 64

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Federalsburg - Rural</u>		Life		TOWN <u>Federalsburg - Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Houston Branch Road</u>				STREET ADDRESS (If rural, give location) <u>Houston Branch Road</u>			
3. NAME OF DECEASED: (First) <u>Sylvester</u>		(Middle) <u>Lee</u>		(Last) <u>Cornish</u>		4. DATE OF DEATH (Month) <u>February</u> (Day) <u>18</u> (Year) <u>1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>May 16, 1912</u>	9. AGE last birthday: <u>43</u> yrs.	IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Mins. <u></u>		IF UNDER 24 HRS. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Junk Dealer</u>		11. BIRTHPLACE (State or foreign country): <u>Caroline County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Cornish</u>				14. MOTHER'S MAIDEN NAME: <u>Annie Shepherd</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY No.: <u>214-32-6257</u>		17. INFORMANT & ADDRESS: <u>Mrs. Charles Magee, Federalsburg, Md.</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <u>Asphyxiation</u>		DUE TO		<u>few minutes</u>	
Antecedent cause(s) (b) <u>Burned - entire body</u>		DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, of street, office bldg., etc.) <u>Home Federalsburg Caroline Md</u>		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2-18-56 1 A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Trapped in burning building</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Dwight D. George</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2/19/56</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Feb. 24, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>		DATE REC'D BY LOCAL REG. <u>February 23, 1956</u>		REGISTRAR'S SIGNATURE <u>Margaret H. Frampton</u>	
24. FUNERAL DIRECTOR <u>J.J. Frampton and Son, Federalsburg, Md.</u>		ADDRESS <u></u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 28 1956

BUREAU V. 3.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01587  
1696 CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Denton</u>	LENGTH OF STAY (in this place) <u>12 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Camp Ground Road</u>		STREET ADDRESS (If rural give location) <u>Camp Ground Road</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>John</u>	(Middle) <u>Calvert</u>	(Last) <u>Fisher</u>	OF DEATH: <u>February 11 1956</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>September 4, 1869</u>
9. AGE last birthday <u>86</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Surveyor</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>County Surveyor</u>	
11. BIRTHPLACE (State or foreign country): <u>Indiana County, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Simon Fisher</u>		14. MOTHER'S MAIDEN NAME: <u>Christine Kunkle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-12-1819</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Ida A. Fisher, Denton, Maryland</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>			<u>720 minutes</u>
ANTECEDENT CAUSE (S) (B) <u>arterio sclerosis and A.V. Block</u>			<u>3 years.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 17</u> , 19 <u>56</u> , to <u>Feb 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 30</u> , 19 <u>56</u> , and that death occurred at 5:30P M, from the causes and on the date stated above.			
SIGNATURE <u>E. Paul Knotts</u>		DATE SIGNED <u>Feb. 13-1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 14, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		LOCATION (City, town, or county) (State) <u>Near Hurlock, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/13/56</u>		24. FUNERAL DIRECTOR ADDRESS <u>J.J. Frampton and Son, Federalsburg, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

FEB 17 1956

RECEIVED

1697

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

Item Film G192 2-21-56 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Denton</u>	LENGTH OF STAY (in this place) <u>50 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Denton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1</u>		STREET ADDRESS (If rural give location) <u>X</u>	
3. NAME OF DECEASED: (Type or Print) <u>Stella Deborah Johnson</u>		4. DATE OF DEATH: <u>Feb 13</u> 19 <u>56</u>	
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>1870</u>
9. AGE last birthday: <u>85</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>house</u>	
11. BIRTHPLACE (State or foreign country): <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Robert Short</u>		14. MOTHER'S MAIDEN NAME: <u>Mary C Harrington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>Ben Johnson, Denton, Del</u>	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death
Immediate cause (a) <u>Causes of Lung</u>			<u>3.4m</u>
Antecedent causes (s) (b) <u>DUE TO</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6-2-1954</u> to <u>Feb 13, 1956</u> that I last saw the deceased alive on <u>2-13-1956</u> and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Ben Johnson</u>		DATE SIGNED <u>2/15/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF <u>2/18/56</u>		LOCATION (City, town, or county) (State) <u>Denton, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/16/56</u>		REGISTRAR'S SIGNATURE <u>Wm D O Jones Jr</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Vincent M. Robertson, Denton</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. R.

1870-1871

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1698

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

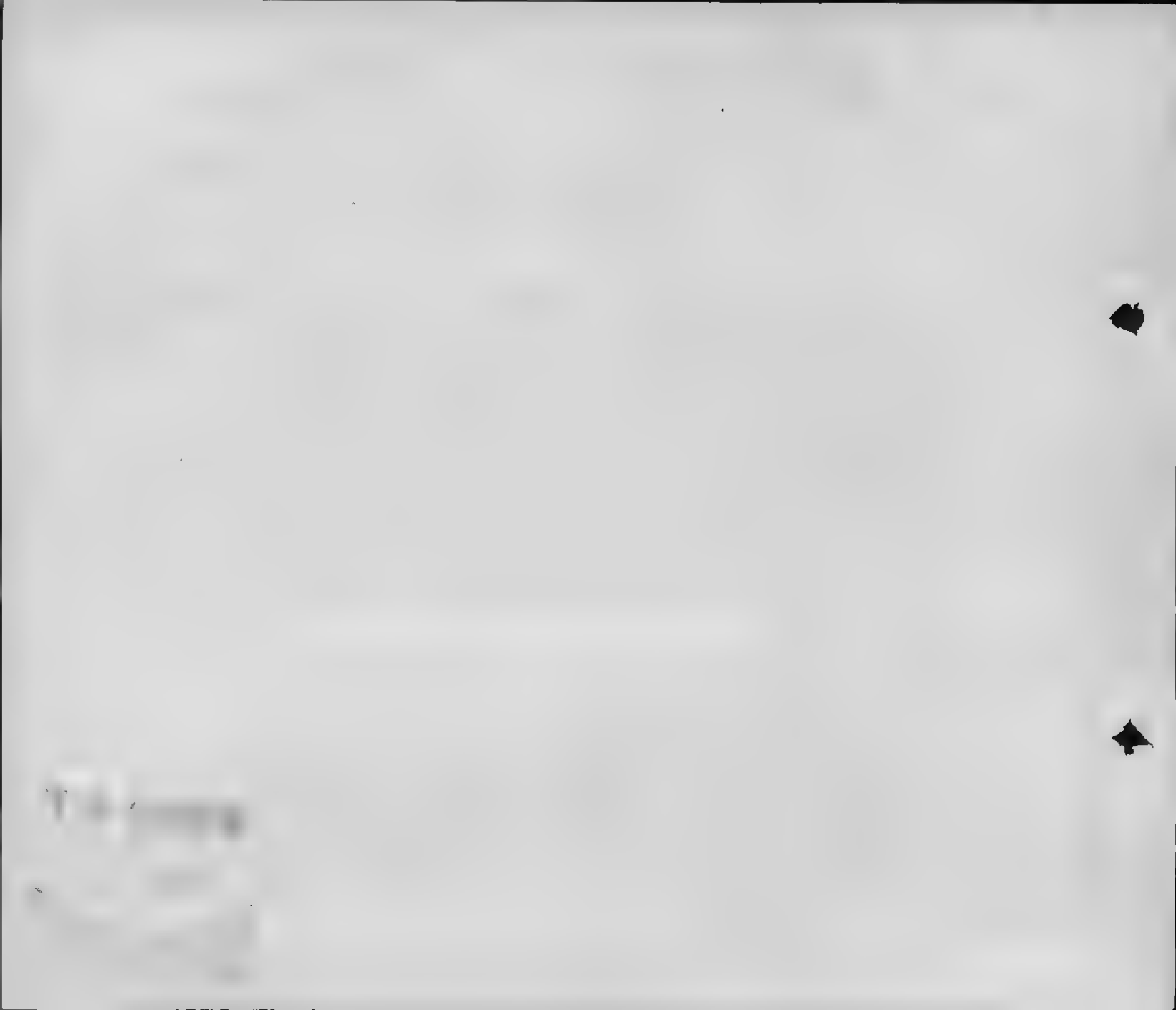
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01589

Reg. Dist.

No. 62

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Caroline</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rural Denton</u>		LENGTH OF STAY (in this place) <u>1 hr</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Rural Denton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>08</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>WILLIAM THOMAS LAYTON JR.</u>				(Month) (Day) (Year) <u>FEB. 24 19 56</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>Apr. 24 1919</u>	
9. AGE last birthday: <u>36</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Tractor</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Trucking</u>		11. BIRTHPLACE (State or foreign country): <u>Carroll County</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME: <u>Wm. Thomas Layton Jr.</u>			
14. MOTHER'S MAIDEN NAME: <u>Felice Mary Jenkins</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>II</u>			
16. SOCIAL SECURITY No.: <u>11</u>				17. INFORMANT & ADDRESS: <u>Mrs. Wm. Thos. Layton, Jr.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
Immediate cause (a) <u>Fractured Cervical Vertebra</u> DUE TO							
Antecedent cause(s) (b) <u>Internal Hernia</u> Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>autoimmune disease</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Denton</u> <u>Carroll</u> <u>MD</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2 24 56/1956 M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>loss control of automobile</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Samuel T. George</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2/25/56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Feb. 28 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Denton</u>		LOCATION (City, town, or county) (State) <u>Denton</u> <u>MD</u>	
DATE REC'D BY LOCAL REG. <u>2/25/56</u>		REGISTRAR'S SIGNATURE <u>Wm D O George</u>		24. FUNERAL DIRECTOR <u>Wm D O George</u>		ADDRESS <u>Denton, MD</u>	





MARYLAND STATE DEPARTMENT OF HEALTH  
**1609** **CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Caroline</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Ridgely</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Caroline</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>Rodger</u> (Middle) <u>X Little</u> (Last)	4. DATE OF DEATH <u>Feb</u> (Month) <u>11</u> (Day) <u>1956</u> (Year)		
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug 8, 1935</u>
9. AGE last birthday <u>21</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Caroline</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Thomas Little</u>		14. MOTHER'S MAIDEN NAME <u>Mary H. Cooper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Thomas Little</u> <u>Wynhill Rd</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>211X</u> Immediate cause <u>Laceration of Spinal Cord. Intracranial Hemorrhage few minutes</u> Antecedent cause(s) <u>Gun Shot wound</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH <u>same</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Street</u> (CITY OR TOWN) <u>Rural Ridgely</u> (COUNTY) <u>Caroline</u> (STATE) <u>MD</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2-12-56</u> <u>4A</u> m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
		HOW DID INJURY OCCUR? <u>Gun Shot wound - Home</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input checked="" type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>Dr. George M. D. George</u> (Degree or title)		DATE SIGNED <u>2/15/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2-16-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Caroline</u>		LOCATION (City, town, or county) (State) <u>Caroline</u> <u>MD</u>	
DATE REC'D BY LOCAL REG. <u>2/15/56</u>		24. FUNERAL DIRECTOR <u>J. King</u> <u>Wynhill Rd</u> ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. A. 1911



## CERTIFICATE OF DEATH

Reg. Dist. No. 62

1610

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Caroline</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Caroline</i>
CITY (If outside corporate limits, write OR and give nearest town) <i>Dorton</i>	LENGTH OF STAY (in this place) <i>35 yrs</i>	CITY (If outside corporate limits, write OR and give nearest town) <i>Dorton</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) <i>Alexander</i> (Middle) <i>Edwards</i> (Last) <i>Wigler</i>		4. DATE OF DEATH: (Month) <i>Feb</i> (Day) <i>8</i> (Year) <i>1956</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Apr. 28, 1866</i>
9. AGE last birthday: <i>57</i> yrs.		10. MONTHS <i>5</i> DAYS <i>10</i> HOURS <i>10</i> MIN.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Self-employed</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Dr. goods</i>	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Edward Wigler</i>		14. MOTHER'S MAIDEN NAME: <i>Mary E. Jester</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO.: <i>10-10-10</i>	
17. INFORMANT & ADDRESS: <i>Stewart Baker, Dorton, Md.</i>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death <i>10 days</i> <i>34m</i>
Immediate cause	(a) <i>Myocarditis acute</i>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) <i>Arterio Sclerosis Generalized</i>	
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *1-25, 1956*, to *Feb. 8, 1956* that I last saw the deceased alive on *2-7, 1956*, and that death occurred at *8 A.M.*, from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>Burial</i>	<i>Feb. 11, 1956</i>	<i>London Park</i>	<i>Baltimore</i>	<i>Md.</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<i>2/9/56</i>	<i>Wm D. George</i>	<i>Wm D. George</i>	<i>Wm D. George, Dorton, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1611

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. ....

01592  
Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Caroline</u> <u>66</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rural Goldsboro</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	<u>None</u>	STREET ADDRESS (If rural, give location) <u>None</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Ray</u>	(Middle) <u>Garfield</u>	(Last) <u>Patterson Jr.</u>	(Month) <u>2</u> (Day) <u>4</u> (Year) <u>56</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>3/7/1885</u>
9. AGE last birthday: <u>70</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Editor</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT U. S. COUNTRY?	
13. FATHER'S NAME: <u>Russ Paterson</u>		14. MOTHER'S MAIDEN NAME: <u>Martha Perice</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <u>10</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>217-37-8608</u>	
17. INFORMANT & ADDRESS: <u>Ray Patterson Jr. Greensboro, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a)..... DUE TO		
Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO		
stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u> )	21c. City or town (County) (State) <u>Rural Goldsboro Caroline Md</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2-4-56 8 A.M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Shot Gun wound - self inflicted</u>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Landon D. George</u>		DATE SIGNED <u>2-4-56</u>
M. D. ASSISTANT MEDICAL EXAM. <u>2-4-56</u>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>2/7/56</u>	NAME OF CEMETERY OR CREMATORY <u>Union</u>
LOCATION (City, town, or county) (State) <u>Goldsboro, Md.</u>		
DATE REC'D BY LOCAL REG. <u>2/6/56</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>J.E. Boules</u>
		ADDRESS <u>Greensboro, Md.</u>

1911

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

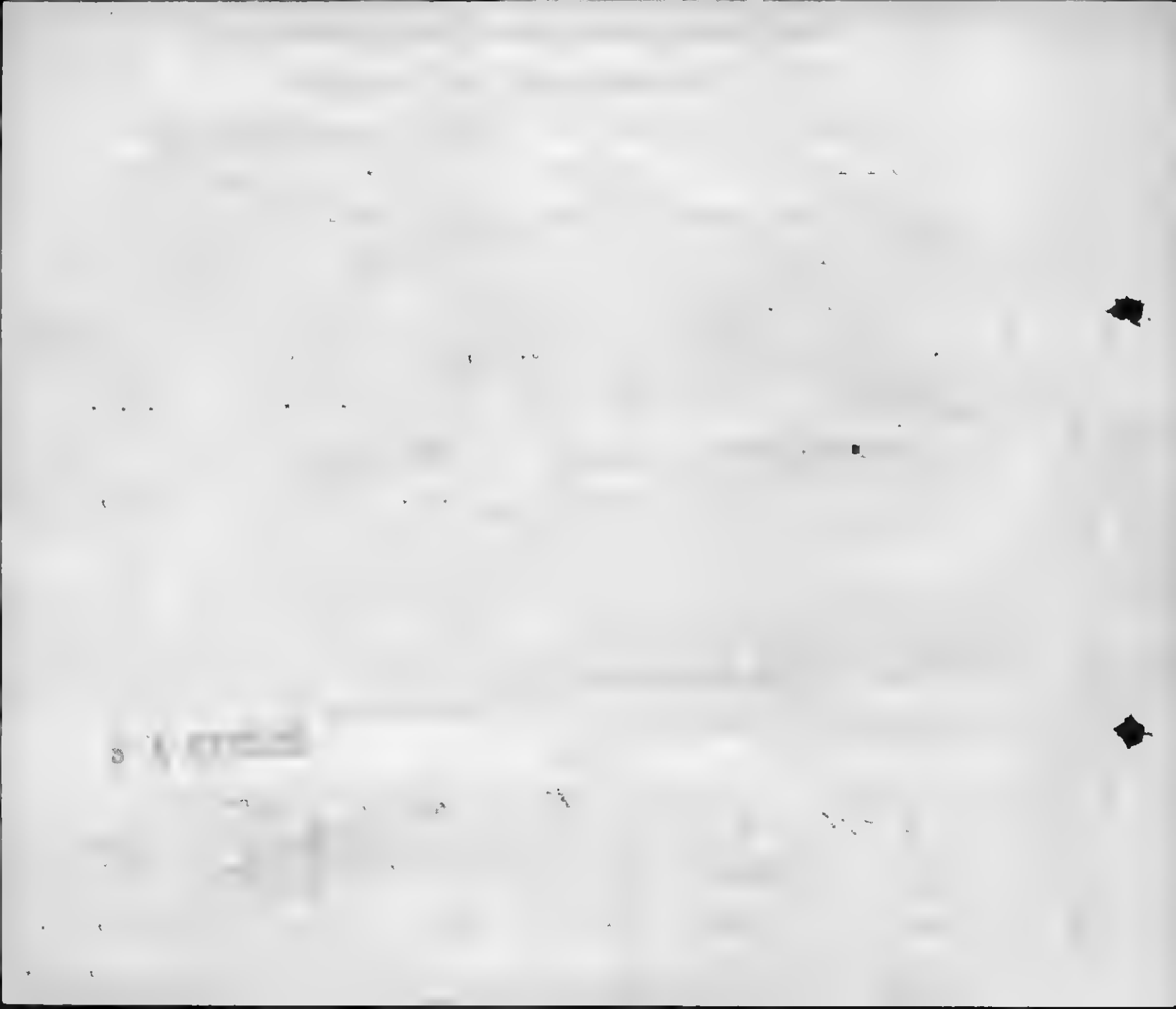
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1612 CERTIFICATE OF DEATH

01593

Reg. Dist. No. 64

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Ma.</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Federalburg (rural)</u>	LENGTH OF STAY (in this place) <u>75 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>rural Federalburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>none</u>		STREET ADDRESS (If rural give location) <u>none</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary G. Pepper</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2/10/1956</u>	
5. SEX <u>fem.</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>married</u>	8. DATE OF BIRTH <u>Oct. 12, 1880</u>
9. AGE last birthday <u>75</u> yrs		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u>75</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Caroline Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph F. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Susan Downing</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS <u>C. A. Pepper Federalburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		10. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-30 AM</u> <u>7:45 AM</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-10-56</u> , 19 <u>56</u> , to <u>2-10-56</u> , that I last saw the deceased alive on <u>2-10-56</u> , 19 <u>56</u> , and that death occurred at <u>7:45 AM</u> from the causes and on the date stated above.			
SIGNATURE <u>W. E. Pearson</u>		ADDRESS (Street, city, town, state) <u>Federalburg Md</u>	
DATE SIGNED <u>2-11-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>2/14/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Concord Cemetery</u>		LOCATION (City, town, or county) (State) <u>near Federalburg, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Feb. 14, 1956</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Harvey W. Pearson Federalburg, Md.</u>	



1613

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Preston—Rural</u>		<u>39 Yrs.</u>		TOWN <u>Preston—Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frazier Flats</u>				STREET ADDRESS (If rural give location) <u>Frazier Flats</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>Lena</u> <u>Van de Visser</u>				OF DEATH: <u>February 29</u> <u>1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>June 25, 1882</u>	
				9. AGE last birthday <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
						Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>Holland</u>		12. CITIZEN OF WHAT COUNTRY: <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Cornelius de Wilde</u>				14. MOTHER'S MAIDEN NAME: <u>Dina Bustran</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-32-1905 B</u>		17. INFORMANT & ADDRESS: <u>William Van de Visser, Preston, Md. R.F. D</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Primary Edema (Nocturnal)</u>						<u>3 hours</u>	
ANTECEDENT CAUSE (S) (B) <u>Chronic Cardiac Decompensation</u>						<u>2 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerotic Heart Disease</u>						<u>12 years.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>—</u>		19B. MAJOR FINDINGS OF OPERATION: <u>—</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? <u>—</u>		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>4/17</u> , 19 <u>57</u> , to <u>2/29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/25</u> , 19 <u>56</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Lucy B. Plummer</u>		M. D. <u>Preston</u>		DATE SIGNED <u>3/1/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF <u>March 3, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Junior Order</u>		LOCATION (City, town, or county) (State) <u>Preston (Linchester) Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-2-56</u>		REGISTRAR'S SIGNATURE <u>Cornelia H. Plummer</u>		24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalsburg, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 5 1956  
BUREAU V. S.

1614

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Preston, Md. P#2-B19/A</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Preston, Md. P#2-B19/A</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Thas Ross Chapel</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) <u>Norris</u> (Middle) <u>Edward</u> (Last) <u>Wilmer</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>February 23 1956</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>e</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>Feb 14, 1956</u>	
9. AGE last birthday <u>9 yrs.</u>		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>Norris Edward Wilmer</u>				14. MOTHER'S MAIDEN NAME: <u>Beulah M. Wilmer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT & ADDRESS: <u>Norris Edward Wilmer</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cardiac hemorrhage</u>						5-6 hours	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>—</u>							
(C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/23</u> , 1956, to <u>2/23</u> , 1956, that I last saw the deceased alive on <u>Feb. 23</u> , 1956, and that death occurred at <u>4:30 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Hayward T. Webb</u>		M. D. <u>633 W. St. Easton, Md.</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 25, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Federalburg, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-25-56</u>		REGISTRAR'S SIGNATURE <u>Cornelia W. Phommaw</u>		24. FUNERAL DIRECTOR <u>J. J. Frampton</u>		ADDRESS <u>Ed. Son, Federalburg, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED

BUREAU V. S.

FEB 28 1956

RECEIVED